The EXECUTIVE EVALUATION CENTER
A division of SMG Innovations, Inc.

Comprehensive Physical Examination

New Patient Medical Questionnaire

Patient Name: _____

Exam Date: _____

Patient Name: _____
Exam Date: _____

Welcome to the Sentara Executive Evaluation Center. Today, in an effort to offer you the greatest opportunity for a long and productive life, you will receive what we believe to be the most comprehensive health evaluation available in this country. The following questionnaire will assist your physician in formulating a comprehensive medical history that we will keep current over the years as you return for annual re-evaluations. You will note that it may be more thorough than other medical forms that you have previously completed, but the additional information will allow your physician to more effectively assess your present and future health concerns. Your responses will be reviewed with you by your physician during your comprehensive evaluation.

A) PRESENT HEALTH STATUS

1. What is your present age? _____
2. What is your gender: ❑ Male ❑ Female
3. How do you assess your present overall health status? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
4. What has been the pattern of your health picture over the past few years?
   ❑ Stable ❑ Improving ❑ Declining
5. How content are you with your present general health?
   ❑ Very content ❑ Somewhat content ❑ Disappointed in present health
6. Do you have a personal physician? ❑ Yes ❑ No
   If yes: Physician Name_____ Physician Phone#_____
   Physician Location_____
7. Would you like a copy of your report to be sent to your physician ❑ Yes ❑ No
8. Are you interested in learning more about the Dedicated Care Center, our membership-based "concierge" medical practice? ❑ Yes ❑ No

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B) PAST MEDICAL HISTORY

1. Did you have any unusual childhood illnesses that left you with either residual abnormalities or health concerns for the future? (i.e. Polio with isolated weaknesses; Rheumatic Fever with heart valve damage, etc.) ❑ Yes ❑ No

   If yes, please explain: _____

2. As an adult, have you had a history of any significant medical illnesses such as:

Heart Disease	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No
Lung Disease	❑ Yes ❑ No	Lung Cancer	❑ Yes ❑ No
High Cholesterol	❑ Yes ❑ No	Unusual Infections	❑ Yes ❑ No
High Blood Pressure	❑ Yes ❑ No	Asthma	❑ Yes ❑ No
Emphysema/COPD	❑ Yes ❑ No	Shortness of Breath	❑ Yes ❑ No

   Other Illnesses/Cancer(s) ❑ Yes ❑ No *(If yes, please explain below)*

   _____

   _____

3. Have you been hospitalized for anything other than surgery at any time in the past? ❑ Yes ❑ No

   If so, for what, and when? _____

   _____

4. What surgical procedures have you undergone in the past, who was your surgeon and when was surgery performed?

   _____

   _____

5. Is there a history of injury in the past that left you with any compromise of function? ❑ Yes ❑ No

   If yes, please explain: _____

6. Have you had any specialized diagnostic procedures in the past? (i.e. heart catheterization, CAT or MRI scans, treadmill studies, etc.) ❑ Yes ❑ No If yes, please explain below (with date(s)):

   _____

   _____

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7. Please list all medications you are taking (including prescription, herbal and over-the-counter medications)? Please make sure to list EVERY medication, including dosages, and directions.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you taking Aspirin 81 mg daily? ❑ Yes ❑ No

Are you taking Vitamin E daily? ❑ Yes ❑ No

Are you taking Folbee or a folic acid/Vitamin B-12 supplement? ❑ Yes ❑ No

8. Please check the vaccinations you have had and list when you received them:

❑ Pneumovax ❑ Hepatitis A / B series ❑ Tetanus (Td / TdAP) ❑ Shingles (Zostavax) ❑ Influenza

Date: _____ _____ _____ _____ _____

9. Have you had any travel-related vaccinations (Typhoid, Yellow Fever, Hepatitis A, etc.)? If so, please list these and the date(s) they were received:

_____

10. Do you have a history of drug or food allergies? ❑ Yes ❑ No

If yes, please list these below and the reaction you experienced:

_____

11. Are you allergic to Iodine, Seafood, or Intravenous Contrast Dye? ❑ Yes ❑ No

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C) FAMILY HISTORY

Father	Mother	Siblings
Is your father living? ❑ Yes ❑ No	Is your mother living? ❑ Yes ❑ No	Are any siblings deceased? ❑ Yes ❑No
How old is he (or age at death)? _____	How old is she (or age at death)? ____	How old are they (or age at death)? _____
Does / did your father have any of the following medical problems? ❑ Heart Disease ❑ Diabetes ❑ Lung Disease/Emphysema/COPD ❑ Cancer ❑ High Cholesterol ❑ High Blood Pressure ❑ Serious Infections ❑ Other Illnesses *Please provide details:*	Does / did your mother have any of the following medical problems? ❑ Heart Disease ❑ Diabetes ❑ Lung Disease/Emphysema/COPD ❑ Cancer ❑ High Cholesterol ❑ High Blood Pressure ❑ Serious Infections ❑ Other Illnesses: *Please provide details:*	Do / did your siblings have any of the following medical problems? ❑ Heart Disease ❑ Diabetes ❑ Lung Disease/Emphysema/COPD ❑ Cancer ❑ High Cholesterol ❑ High Blood Pressure ❑ Serious Infections ❑ Other Illnesses: *Please provide details:*

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D) SOCIAL HISTORY

Tobacco Use	Alcohol Use	Caffeine / other Drug Use
Do you currently use tobacco products? ❑ Yes ❑ No How many cigarettes do you smoke daily? _____/day For how many years have you been smoking _____ years	Do you now drink or have your previously drunk alcohol regularly? ❑ Yes ❑ No	Do you ingest caffeine regularly? ❑ Yes ❑No
	How many drinks do you drink daily? _____/day	How many caffeinated drinks do you drink daily? _____/day
Have you ever used tobacco products? ❑ Yes ❑ No If so, how many cigarettes did you smoke daily? _____/day For how many years did you smoke _____ years	Do you think you have / had a problem with drinking? ❑ Yes ❑ No	Do you think you are addicted to caffeine? ❑ Yes ❑ No
Do you / Have you: ❑ ever use other forms of tobacco products? ❑ want to quit? ❑ Think you can quit? ❑ ever been able to quit?	Have you ever: ❑ felt the need to cut down on our drinking? ❑ felt annoyed by others criticizing our drinking ❑ ever felt guilty about drinking? ❑ ever felt the need for a drink first thing in the morning?	Do you / have you ever: ❑ had caffeine withdrawal symptoms such as headache ❑ used any "recreational" / street drugs? If so, please list them:

Family / Work / Fitness

1. What is your marital status?

   ❑ married ❑ remarried ❑ divorced ❑ widowed ❑ engaged ❑ single

2. Are you satisfied in your present marital state? ❑ Yes ❑ No

3. Are there topics that you would like to discuss in complete confidence regarding your social or sexual life? (HIV testing, etc.) ❑ Yes ❑ No

4. Do you have children? ❑ Yes ❑ No

   If "yes", please list their ages, genders and any medical problems they have:

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_____

_____

5. Are you employed? If so, in what capacity? _____

6. Are you satisfied with your present lifestyle and daily responsibilities? ❑ Yes ❑ No

7. Are your stress levels acceptable to you? ❑ Yes ❑ No

8. Do you have plans for five years into the future that seem fulfilling? ❑ Yes ❑ No

1. Are you exposed to toxins, irritants, allergens, etc. in your employment or home? ❑ Yes ❑ No

If "yes", please indicate how and when _____

2. How many hours per week do you devote to sedentary activities? _____

11. How much vacation do you take in an average year? _____

12. When was your last vacation of one week or more? _____

13. What is the approximate length of your longest annual vacation? _____

14. What is your assessment of your present state of physical fitness?

❑ Poor ❑ Below Average ❑ Average ❑ Above Average ❑ Excellent

15. Do you have a regular exercise program? ❑ Yes ❑ No

If so, what is it?_____

16. Do you participate in strenuous sports activities? (Tennis, swimming, running etc.) ❑ Yes ❑ No

If "yes", what activities: _____

17. Are you aware of the association of improved longevity with regular exercise? ❑ Yes ❑ No

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E) REVIEW OF SYSTEMS

If you answer "Yes" to any of these questions, please provide further details in the space below each question:

General:

1. How would you assess your overall health picture?

   _____

   _____

2. What are the weakest points of your overall health? (Smoking, alcohol, stress, sedentary lifestyle, family history, etc.)

   _____

Head:

1. Do you suffer from headaches? ❑ Yes ❑ No

   If so, have they been "labeled"(i.e. migraines, tension, cluster, etc.) ❑ Yes ❑ No

   _____

2. Is your hearing compromised? ❑ Yes ❑ No

   If "yes", is there a past history of acoustic trauma, ear disease, or family history of a hearing deficit?

   _____

3. Have there been any changes in your vision in the past 1-2 years? ❑ Yes ❑ No
4. Have you ever noted transient changes in your visual fields? (i.e. "blind spots") ❑ Yes ❑ No

   If so, in which eye and for how long? _____

5. Have you had an eye examination within the past two years? ❑ Yes ❑ No
6. Do you have a history of allergic symptoms? (sniffling, nasal congestion, etc.) ❑ Yes ❑ No
7. Do you have a history of hoarseness, or other recurrent abnormalities of voice? ❑ Yes ❑ No

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Neck:

1. Is there a history of neck pain or stiffness? ❑ Yes ❑ No

   If so, are there provoking factors? _____

2. Is there a history of swollen glands in the neck? ❑ Yes ❑ No

   If so, are they associated with a sore throat, or other signs of infection? _____

3. Is there any history of thyroid enlargement (goiter), or neck tenderness? ❑ Yes ❑ No

Lymphatic System:

1. Is there any history of persistent swollen glands of the neck, underarms, groin or thighs? ❑ Yes ❑ No

   If yes, please describe: _____

Chest:

1. Is there any history of chest pain, shortness of breath, asthma, emphysema, COPD, cough, chest congestion wheezing, or diminished exercise tolerance? ❑ Yes ❑ No

   _____

   _____

Heart:

1. Is there any history of exertional chest pain, angina, heart attack, congestive heart failure, tightness, burning, fullness, or any other unusual sensations noted with activity? ❑ Yes ❑ No

   _____

   _____

2. Is there a history of skipped heartbeats, inappropriately rapid or irregular heart rhythm? ❑ Yes ❑ No

   _____

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Abdomen:

1. Is there any history of chronic or recurrent abdominal pain, indigestion, nausea, vomiting, diarrhea, constipation or previous endoscopy procedures? ❑ Yes ❑ No

2. Is there a history of belching of stomach acid, severe or recurrent "heartburn" ❑ Yes ❑ No

   If so, please list provoking factors: _____

3. Have you ever noted jaundiced skin or Coca-Cola colored urine? ❑ Yes ❑ No

4. Have you noted any change in bowel habits, such as dark stools, diminished caliber of the stool, straining at defecation, or a persistent feeling of the need to evacuate the bowel unrelieved by passage of stool? ❑ Yes ❑ No

   If yes, please specify _____

5. Have you or anyone in your immediate family (parents, grandparents, children, siblings) ever had any of the following conditions?

Colon Cancer	❑ Yes ❑ No
Colon Polyps (malignant or benign)	❑ Yes ❑ No
Familial Adenomatous Polyposis	❑ Yes ❑ No
Other Major abdominal disease	❑ Yes ❑ No

   If yes, please specify_____

   _____

6. Have you had prior colonoscopy, flexible sigmoidoscopy or upper endoscopy (EGD)? an in and an in and an in and an in and an in and an in and a you and an in and in a you and an in and ❑ Yes ❑ No

   If yes, when did you have it and what did it show? _____

   _____

Genitourinary Tract (Female):

1. Do you have a history of recurrent bladder infections? ❑ Yes ❑ No

2. Do you have a history of recurrent vaginal infections? ❑ Yes ❑ No
   If so, are they usually precipitation factors, such as antibiotic therapy? ❑ Yes ❑ No

Patient Name: _____
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3. How many pregnancies have you had? _____
   How many full-term deliveries? _____
   How many miscarriages? _____
   Did you breast-feed your children? ❑ Yes ❑ No

4. Were you ever told of diabetic tendencies during pregnancy? ❑ Yes ❑ No

5. Do you have any questions about your sex drive or sexual performance? ❑ Yes ❑ No

6. When was your last Pap smear? _____
   Have you ever had an abnormal Pap smear? ❑ Yes ❑ No
   If so what actions followed that discovery? _____

7. When was your last mammogram? _____
   Have you ever had an abnormal mammogram? ❑ Yes ❑ No
   If so when was this discovery? _____
   If so what actions followed this discovery? _____

8. At approximately what age did your mother enter menopause?_____
   Have you experienced hot flashes, mood swings, personality changes or other manifestations or menopausal syndrome? ❑ Yes ❑ No

   If so, are they resolved, diminishing or increasing? _____
   Are you now, or in the future, planning to use hormonal replacement therapy to diminish menopausal changes or complaint? ❑ Yes ❑ No

9. Have you undergone bone density studies in the past? ❑ Yes ❑ No
   If so, what were the results? _____

10. Do you take calcium supplements? ❑ Yes ❑ No
    If so, in what form? _____

Genitourinary Tract (Male):

1. Is there a history of bladder or prostate infections? ❑ Yes ❑ No

2. Have you been told of prostate enlargement in the past? ❑ Yes ❑ No

3. Do you have a history of diminished size and force of the urinary stream as compared to that of age forty? ❑ Yes ❑ No

4. Is your sexual performance adequate? ❑ Yes ❑ No

5. Is there is a problem that would justify further investigation? ❑ Yes ❑ No

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Extremities:

1. Is there a history of chronic or recurrent joint pain, swelling, stiffness or redness. ❑ Yes ❑ No
2. Is there a history of muscle weakness, tenderness or loss of muscle mass? ❑ Yes ❑ No
3. Is there a history of unexpected changes in the fingernails or toenails? ❑ Yes ❑ No
4. Is there a history of pain in the muscles of the legs with walking that quickly clears with cessation of activity? ❑ Yes ❑ No
5. Is there a history of color or temperature changes of the hands or feet? ❑ Yes ❑ No

Central Nervous System:

1. Is there a history of motor or sensory abnormalities of any area of the body? ❑ Yes ❑ No
2. Is there a history of unusual levels of anxiety or depression? ❑ Yes ❑ No

Other Pertinent Medical Information:

1. Are there other points that you feel should be included in your medical history?

_____

_____

Patient Name: _____
Exam Date: _____

PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION:

*NAME:*_____

*HOME ADDRESS:*_____

E-MAIL ADDRESS: _____

*HOME PHONE:*_____ *WORK PHONE:*_____

*OCCUPATION:*_____

*DATE OF BIRTH:*_____ *S.S.#:*_____

*HOW DID YOU HEAR ABOUT OUR CENTER?*_____

_____

Patient Name: _____
Exam Date: _____

ADVANCED IMAGING CENTER

SENTARA

NON-IONIC CONTRAST CHECKLIST

Any previous X-ray studies using intravenous contrast media?(IVP, CT, Angiogram) ❑ Yes ❑ No
Any previous reaction(s) to IV contrast media? What Type? ❑ Yes ❑ No
Any allergies to food, medications or other Allergy? ❑ Yes ❑ No

Please specify:
Any history of Asthma: ❑ Yes ❑ No
Any significant HEART DISEASE? ❑ Yes ❑ No
Sickle Cell Anemia? ❑ Yes ❑ No
Any history of Diabetes Mellitus? (Sugar diabetes) ❑ Yes ❑ No
If yes to above, are you taking GLUCOPHAGE/METFORMIN? ❑ Yes ❑ No
If no, what medication do you take?
Any type of KIDNEY DISEASE? ❑ Yes ❑ No
If yes to above question, are you on Dialysis? What days?
Are you scheduled for other tests that will require IV contrast with the next 72 hours?
If so, please specify:
Any history of: Phechromocytoma, Hyperthyroid, mastocytosis, Multiple Myeloma or Myasthenia Gravis? ❑ Yes ❑ No
Any history of Cancer? If so what type? ❑ Yes ❑ No
Any chemotherapy or radiation treatment, past or present? ❑ Yes ❑ No
Why was this test ordered? What are your symptoms? ❑ Yes ❑ No

_____
_____

Have you had any surgeries/operations of any kind? If so what type?

Surgery	Date
_____	_____
_____	_____
_____	_____

Are you pregnant or do you suspect that you are pregnant? ❑ Yes ❑ No
Date of last menstrual period:_____

Note: If is has been ten days since your last menstrual period and there is a possibility that you may be pregnant, you must let your technologist know, your test should be rescheduled or a consent signed.

Name:_____ Date: _____

Patient Name: _____
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SS# _____

COMPLETE THIS SECTION FOR CARDIAC CALCIUM SCREENING CT:

Has a doctor ever told you that you have the following conditions?

Heart attack (myocardial infarction, coronary occlusion, coronary thrombosis) ☐ No ☐ Yes
Angina ☐ No ☐ Yes
Heart Failure (congestive heart failure or congestive heart disease) ☐ No ☐ Yes
High blood pressure ☐ No ☐ Yes
High cholesterol (elevated LDL) ☐ No ☐ Yes

Has a doctor ever told you that you have the following conditions?

Low HDL cholesterol ☐ No ☐ Yes
Do you know your cholesterol level? If so, what is it?_____
Stroke ☐ No ☐ Yes
Pulmonary embolism (blood clot in the lung) ☐ No ☐ Yes
Diabetes ☐ No ☐ Yes
If yes, how do you control your diabetes?
Insulin Injection ☐ No ☐ Yes
Oral anti-diabetes medications ☐ No ☐ Yes
Diet ☐ No ☐ Yes

Have you ever had any of the following?

Coronary artery bypass surgery (CABG) ☐ No ☐ Yes
Coronary angioplasty or balloon angioplasty with stent placement ☐ No ☐ Yes
Surgery for peripheral vascular disease ☐ No ☐ Yes
Any other heart or lung surgery ☐ No ☐ Yes
If yes, please specify_____

Do you have high blood pressure? ☐ No ☐ Yes
Do you have an irregular heartbeat? ☐ No ☐ Yes

Has anyone in you immediate family (parents, children, grandparents, siblings) ever had any of the following conditions?

Heart attack (myocardial infarction, coronary occlusion, coronary thrombosis) ☐ No ☐ Yes
If yes, what gender? ☐ Male ☐ Female At what age?_____
Angina ☐ No ☐ Yes
Stroke ☐ No ☐ Yes
Diabetes ☐ No ☐ Yes
Hypertension ☐ No ☐ Yes
Heart failure (congestive heart failure or congestive heart disease) ☐ No ☐ Yes
Pulmonary embolism (blood clot in lung) ☐ No ☐ Yes
Other major disease ☐ No ☐ Yes

Patient Name: _____
Exam Date: _____
If yes, please specify_____

_____

CONSENT FOR PERFORMING SCREENING CT SCANNING FOR
The Executive Evaluation Center

Advanced Imaging Center (AIC) – Sentara Healthcare

Patient Name_____

Examination Date_____

Explanation of Procedures

You have asked us to perform a screening CT examination on you. This document explains the test, their risks and possible benefits to you. We also have other materials describing the scans we are performing and the diseases for which we are testing. If you have not already seen these materials, please ask us.

CT scanning is a routine x-ray examination that has been used for many years. However, it has been used as a screening test for coronary artery disease, lung cancer, and abdominal cancers for only the past few years.

For the chest CT scan for lung cancer:

- No preparation is required.
- You must lie on your back for a few minutes while the scan is set-up then you must hold your breath during the scan itself. The scanning intervals last for only a few seconds.
- The entire examination usually takes less than 15 minutes.

For the Coronary Artery Calcium Scoring CT scan:

- No preparation is required.
- You will have EKG wires taped to your chest that will help the scanner time the X-rays with the heartbeat to obtain the best images. You them must lie on your back or stomach on a CT scanner table and go through the CT "gantry" or ring. You must hold your breath for a few seconds while the X-ray scan is taken.
- The entire examination usually takes less than 15 minutes.

For the CT scan of the abdomen, pelvis and for colon cancer:

- You will need to clean out your colon before the test, meaning a change in diet and using laxatives and medications that cause frequent, liquid bowel movements.
- A small tube will be inserted into you rectum and used to inflate your colon with air until you feel full.
- You will receive an IV injection of contrast dye.

Patient Name: _____
Exam Date: _____

- Scans will be taken with you on your back and on your stomach. You must hold your breath for several seconds at a time while scans are being taken. Your colon will feel full during the few minutes of the examination.
- When the test is done, you expel the air.
- The entire examination usually takes less than 15 minutes.

Benefits

The purpose of this test is to provide you information about your health that you may use to prevent or treat disease. However, only a small percentage of people have abnormal scans.

Recent studies have shown that helical CT can detect cancers earlier than symptoms, conventional chest radiographs, and sputum analysis. Detection can occur at a very early stage, before the tumor has spread, or at an advanced local stage. Eighty percent (80%) of cancers detected by CT are Stage I, which is a great improvement from the 5-15% Stage I now detected worldwide. However, there is still controversy if early detection would decrease **mortality** (number of patients who die from the disease relative to the number screened), even though it improves **survival** (number of persons alive following detection and treatment of the disease compare with the number of persons diagnosed with the disease).

Risks and Disadvantages

Detecting a disease early may not mean it is curable or treatable:
The disease may only be found after it is too late to successfully treat. In this case, you may suffer from knowing that you have a serious disease for a longer period of time.

Earlier detection can also lead to more aggressive treatment:
Aggressive treatment (such as with chemotherapy or surgery) may be done for earlier disease in the hope that it is curable. In this case, you could have more side effects from these treatments if you waited until the disease caused symptoms.

A positive screening test may lead to needless operations or medical procedures that cause side effects:
The CT scan is NOT 100% accurate. Some types of diseases may also be missed or other tests may be needed to clarify confusing findings from the screening scan. Screening scans reduce risk by using lower radiation exposure protocol. Diagnostic scans are usually done with higher X-ray doses and other scanning methods to enhance the images.

Follow-up test and treatment can be expensive:
While insurance is more likely to cover additional tests done after a positive screening scan, there is no guarantee that such test or other procedures will be completely paid for by insurance.

There is small risk of perforation of the colon with the CT examination of the colon:

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The risk of perforation of the colon is extremely small because only a small tube is inserted into the rectum and only air is used to fill the colon. The risk is substantially less than with a colonoscopy.

The screening CT scan uses radiation:
There is only a small risk from the relatively small doses of X-ray used. This is about the same or less radiation that is used for other types of CT scans.

Questions

If you should have any questions about this examination, our radiologists or your treating physician will be happy to answer them for you.

Signatures

My signature below indicates that I HAVE READ AND UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT, AND HAVE HAD ALL OF MY QUESTIONS REGARDING THE CT SCAN ANSWERED TO MY SATISFACTION. I agree to have the CT scans checked below. I will receive a copy of the consent form.

- ❑ CT Screening for Cardiac Calcium Scoring
- ❑ CT Screening for Lung Cancer
- ❑ CT Screening for Abdomen and Pelvis with IV Non-ionic contrast injection
  - ❑ (Complete Non-ionic contract checklist)
- ❑ CT Virtual Colonoscopy Screening

_____ _____
Signature of Participant Date

_____ _____
Signature of Physician Obtaining Consent Date

_____
Printed Name of Physician Obtaining Consent